UTAH DIGITAL HEALTH SERVICE COMMISSION MEETING
Thursday January 7, 2021, 10:00 AM – 12:00 PM MT
Attendance is Remote Only

meet.google.com/mix-bhru-vhf
Phone Number: 559-419-0735
PIN: 367 573 773#

Minutes

Members Present: Rand Rupper (Chair), Dallas Moore, Mark Dalley, Matt McCullough, Preston Marx, Sarah Woolsey, Todd Bailey, Trish Henrie-Barrus, Henry Gardner

Members Absent: Ken Schaecher, Ben Hiatt,

Staff Members: Navina Forsythe (DOH), Valli Chidambaram (DOH), Humaira Lewon (DOH), Huaizhong Pan (DOH), Robert Wilson (DOH)

Guests: Ambrish Sharma, Sid Thornton, Dirk Anjewierden, Rob Ence, Patrice Nicholes, Wu Xu, Brian Chin, Guy Dansie, Marc Watterson, Matt Hansen

1. Welcome and Introductions

Mark Dalley welcomed everyone to the remote Google Meeting and asked for a motion of approval for the minutes.

2. Approve November Meeting's Minutes

November meeting minutes were reviewed.

MOTION :
Todd Bailey made the motion for approval, Trish Henrie-Barrus seconded, and all committee members voted in favor without any changes.

3. Discussion Items

A. Telehealth Update : Matt McCullough

Matt McCullough shared two things that are happening locally. With CARES Act money UETN was able to purchase a number of Telehealth kits that are being put in a hundred and seventy-five schools in mostly

rural school districts in Utah. Intermountain Healthcare has also purchased Telehealth kits that they're going to be putting in more urban Title One schools. There is collaboration on how they're going to be deployed and used by School nurses to improve access for students.
Funding for Telehealth: Matt mentioned the Covid Relief Bill signed on December 27th 2020 and how it was relevant to telehealth. The bill includes an Appropriations Act as well as a covid stimulus. The bill includes funding for broadband and telehealth connectivity. There's been a big push for emergency Broadband subsidies. There's a $50 per month subsidy for internet for low-income and veteran populations. There's also a $75 per month discount on internet service on tribal lands and subsidies for low cost devices like computers and tablets. Matt then explained another program - the FCC covid-19 telehealth program, which came with two hundred million dollars funding last year. A few states received a lot of awards, and some states received no awards from this program. So the new bill allocates two hundred and fifty million dollars to the same program with more oversight and a goal of ensuring funding goes to organizations in every state. The purpose of this funding is to help states start telehealth programs.

Matt then discussed things related to direct care type services with telehealth. Medicare in the bill allows rural emergency hospitals to be identified as originating sites and eligible for reimbursement. Patients located at rural emergency hospitals would be eligible to receive telehealth services from those sites. Prior to the bill, mental health services had to be rendered in rural areas. In this bill, there's an exemption to that so telehealth services can be used to diagnose, evaluate, or treat a mental health disorder in rural or urban areas, including in patients' homes. There is a caveat to this reimbursement model- the patient should have had an in-person visit with the provider in the six months before receiving the telehealth visit. There are a lot of details in the bill that impacts telehealth. Matt wanted everybody to know that if there's ever been a time for the advancement and adoption of telehealth, this is it.

Mark asked if most of the money was allocated through grants, and Matt said the first wave of Cares funding - a lot of it came directly through the state. This time most of the funding will be through grants and programs like the Federal Communication Commission programs and the USDA. Matt shared that they posted Telehealth 101 training courses. When they went live in December 2020 they had 8,000 registrations and over 3500 completions.

B. Social Determinants of Health Update: Navina Forsythe

Navina shared an update on social determinants of Health that's evolving. There is a big group that's been pulled together by the Lovett partners and they've been looking at different options for furthering interoperability and collaboration in regards to social determinants of health and looking at some other state models. Navina has been in meetings where the plan is to work on an APD using high-tech funding. In the next nine months they are going to try to get a rush application in to help with Midas platform that can be interoperable with both 211 and the blueprint solution which is the solution the governor's office is working on to pull together and collaborate between a bunch of social service agencies as well as potentially a mobile app. They're hearing from the governor's office that they will put up the match fund and the administrative cost. These efforts need to allign with our state HIE plan and Navina has reviewed the alignment. Looking forward to movement and Navina will keep everyone updated as they move forward.

Brian Asked Navina what the long term game plan plan for sustainability of the social determinants is. It wasn't quite clear if there's been any update of how they're gonna support this long-term financially.

Navina said there are requests for ongoing funds. Some of it is through current infrastructure and and the collaboration of partners. It may not be totally fleshed out yet.

C. UHIN Update : Brian Chin

Brian shared a little about what UHIN is doing, saying they were set up as a pair organization to conduct EDI transactions X12 primarily payment information. Brian said they focus heavily on both the HIE and EDI of creating sort of a network of networks and Integrations to create a connectivity and an interoperability to our members that participate in our Network. Focus a lot on routing transactions of the appropriate party. This has been for treatment payment and operations under the HIPAA. This is facilitated through covered entities that we work with in our members and act as a business associate with them. Brian shared that one of the things that they develop is a common infrastructure and architecture for their membership that can serve a number of their use cases. So one of the things that they do at Union is a standard development organization that focuses on data models and common formats that can be used to facilitate the efficient and effective transmission of data information to their membership.

For the clearinghouse, V.A.N. stands for value added network. This is a post office type concept that previously just routed information and data. Brian mentone that they've moved to a Clearinghouse recently in the past five years and are continuing to iterate on their development lifecycles to be a more robust Clearinghouse and actually manipulate and do things validate transforming the healthcare data that is in their Network.
Brian shared one of the things that they did in 2021 is they'll finalize and move to what they call MYUHIN. This is a provider solution that is replacing what they call UHIN which is very old and antiquated and it goes back to 2001. It's really the front-facing portal for a lot of their providership members. Brian said they pride themselves in sort of being the low-cost solution for a lot of providers to be able to transact data and information and that is a lot of their business model. Their pricing has remained unchanged for long periods of time to facilitate that low cost leadership that they pride ourselves on.

On the CHIE side of things, they've moved to a best of breed stack in 2013. They are continuing to think about how to move forward in technology space. They've moved from opt-in, meaning that you had to opt into the HIA to share your data versus to opt out meaning that they still allow people to opt out of our clinical health information exchange. However they are often in under TPO and under the agreements with their data sources and their healthcare entities that are our members.

Bian shared a snapshot of the core capabilities of their key and functionality a lot of these things. Brian discussed some nationwide HIE challenges. It is very expensive and some of the use cases don't line up to the value add that was hoped at the beginning and it's really about bringing people together making them

inclusive. They want to be able to share information and data appropriately and securely for the benefit of their patients and their members that they're treating.

There has been a lot of consolidation, a lot of different business model changes in the HIE space nationwide and and we only anticipate that that will continue to grow and evolve in the future. Brian shared their vision at Union is to create a more connected Healthcare System that drives integration collaboration inclusiveness. This has been one of the founding sort of ideals for UHIN since UHIN was created and the mission here is to increase the adoption and leverage appropriate technologies that assist healthcare organizations to care for patients and share information and to really run their business at a cost-effective manner that makes sense for them.

Brian mentioned one of the newer things that they've had is their values that they want to emulate as a company and organization. They are focusing on these internally, the future of healthcare and where do they see their position of healthcare and it going forward. Integrations of a more connected world through technologies.

Brian mentioned their healthcare platform and that's sort of a modern it monitorization effort that started in 2020 and they are continuing to finalize and finishing touches in 2021. They want to expand upon their data or healthcare platform to be able to offer other applications and solutions that the members will find useful. Brian said they are very much a build with company and want to build with their membership and are only as good as their members and how they are serving them. Brian ended with that was a little bit of their product mindset and what they are hoping to strive for and you can see that it starts with sort of iterative development cycles of their software engineering and their technology stack that they build, modernize, maintain.

Sarah Woolsey had a comment, mentioning that in the Telehealth legislation that was passed last year, in terms of working toward coverage parity for providers, they did insert an ask about information sharing. If you go to an InstaCare and a televisit that if you tell them primary care that they're obligated to get that information back. She wanted to make sure about awareness of that part of the law. She said she hopes it retains because one of the things that's important in the virtual world is having access to a medical home where appropriate. HIE could be a really great opportunity for us to consider, making people aware outside of our walls the opportunity of UHIN to serve them in that way and then to to again promote us to be connected to it where appropriate. Just wanted to see if that was on the radar and if there's been any thought about that aspect of our Telehealth law for Brian.

Brian responded that care coordination has always been on their radar and their map. They do currently connect with some Telehealth people on the Clearinghouse side of things on not the HIE site, but it's on the radar but they need to set the foundation first. The goal is to focus on that foundation first before they can go into sort of these other use cases and build on top of a stable foundation.

D. Aging Issue and Health Information Technology

Intro: Henry Gardner gave an intro and thanked everyone. Sarah finished introductions of the presenters.

Sarah stated we all know Dallas, he's part of our commission. Thank you for being here as a pharmacist at the University of Utah. He'll kick us off talking about medication safety. We then have Guy Dansie who's the EMS System Program Leader and Manager for Department of Health. Next is Rob Ence with Utah Commission on Aging who's been leading that commission's been leading the charge on electronic physician order of lysis staining treatment advanced directives work. Lastly we have a very important leader in for population and care team, the long-term care organization Dirk Anjewierden is here from the Utah Health Care Association and can fill gaps of what we miss.

Sarah mentioned this panel has asked her to facilitate and she thanked Henry for setting it up. There's an element of updating but also what are opportunities being used, the power that this commission has to raise up areas and remove barriers. We've asked our presenters to talk about what are potential areas we can continue or newly champion, what are opportunities using. The goal being that digitally there's a huge opportunity.

Medication Safety : Dallas Moore

Dallas Moore was happy to be a part of the discussion today and said pharmacy plays a huge role in how we take care of our more mature adults especially here in Utah. He introduced himself as the Director for pharmacy informatics and technology University of Utah health. Has been a licensed pharmacist for about 26 years, but worked in pharmacy even as a technician before becoming a pharmacist for about 30 years total.

Dallas reviewed some slides and discussed some of the numbers of why medications are important to consider with our senior citizens, depending on how medications are taken. It can be a major setback when doses are skipped or too much medications given then it can be detrimental or deadly. Dallas reviewed some slides that shared some statistics. More than 10,000 people turn 65 every day in the United States and people are living longer and having healthier lives. We need to understand that medications, especially non-adherence is actually quite widespread among our seniors. Some of the statistics from the Department of Health and Human Services show that about 55% of the elderly are non-compliant with prescription meds meaning that they don't take the medication exactly how the their doctors had prescribed it or instructed them to take it. Also, approximately 200,000 older Americans are hospitalized annually because of adverse drug reactions, it's about 16,000 per month across the United States which is a big number.

The Loan Institute is a nonpartisan think tank located in Massachusetts, advocating new ideas for healthcare and they've published a number of studies mainly focused on medication utilization in best practices. More than 40% of older Americans report regularly to take five or more medications and almost 20% take more than 10 medications and every day approximately 750 older adults are hospitalized due to a serious side effects from their medications. They noted the burden of taking multiple medications have been associated with greater healthcare costs and increased risk of adults drug events, drug interactions medication non-adherence reduced functional capacity and multiple geriatric syndromes. Dallas reviewed common types of reasons why seniors don’t tale medications the way there are prescribed.

Dallas said a lot of these are pretty simple to understand and we need to come up with what are some solutions that can help with those obstacles and hopefully this group can pick a couple of things that can be a focus going forward that as a group or as a state we can we can try to improve. The first thing Dallas reviewed was finaces and problems seniors experience from limited income. There are also cases where they have enough income to live and medications become increasingly expensive. In pharmacy, especially in an oncology situation, we're starting to see regimens, medication treatments exceeding a million dollars per treatment.

Finances can really take a lot of different shades and need to be addressed.

Some of the very simple ways that we can manage the ink or the cost of medications is obviously choosing a generic medication which are cheaper and can do the same job as brand names. You can research financial assistant programs for prescription medications. Many pharmacies actually offer their own discount program. If the senior does not have their own insurance, they can go in and ask, GoodRX is a wonderful example of that and the pharmacists may be aware of other situations or opportunities. At the University of Utah we've recently become an advocate for GoodRx and we utilize GoodRx in our inner insurance benefits as well as just to our patients that come to our pharmacies and what that allows is not only for the patient to to recognize a cheaper cost on a medication but also to look across local pharmacies in the area to see if somebody may have a cheaper cost. There's some opportunities there for our seniors and all patients feel utilized discounts there. Dallas mentioned another option is the Medicare Part D plan. Another issue with a pandemic is patients having trouble getting to a pharmacy and picking up those medications. Dallas said they have a lot of options for mail order and that really has been a big win for patients. They are trying to identify new ways to provide medications to patients and are currently working with their retail pharmacies at the university to figure out ways to work with Uber and Lyft and they actually offer kind of a business partner model so that if a patient didn't want to come to the pharmacy, an Uber driver would come pick it up and drop it off to the patient and get reimbursed. So these are some of the out of the box ways of thinking and things they are currently working on to try to improve. Another step into this is the telepharmacy as mentioned with Matt, the telehealth and how important that is. Dallas touched on medication overlad and how to identify with prescriptions which medications can be removed. Dallas reviewed issues like vision loss, hearing loss, a memory loss and how as patients get older they deal with these. Reviewed some solutions and opportuninties there.

Sarah made a comment that they talked about the cancel RX function the discontinuation function and it's interesting to hear the update that the team is able to do it but we're missing on the end of smaller pharmacy. Sarah said she is going to put a placeholder for us to consider as a commission readdressing the cancel RX opportunity so that people don't either spend money on drugs they're not using and or have drugs around that aren't correct for them for those safety issues.

Transition of Care : Guy Dansie and Patrice Nicholes

Guy Dansie thanked everybody for the opportunity to give an EMS perspective on some of the data that is collected and maybe ways that they can be used. He introduced Patrice Nicholes and Patrice is the expert and put together the slides and will lead the discussion.

Patrice gave a snapshot of EMS and seniors in the state. 39% of EMS patients in Utah are over 60 and EMS usage by 70 to 79 year olds has increased 20% since 2018 and keep Covid in mind as well. In 2020 there were 94,127 EMS calls for individuals over 60, of these 2,681 were treated and released against medical advice. 9,349 were treated and released per protocol, 5,267 were evaluated but did not require treatment or transport. Already we have 17,000 patients that have received treatment or were seen by EMS, but they are not going to show up in hospital data because they didn't go to the hospital. This is this is an opportunity, especially for Community Health and things like that to capture data that's not captured in other places. 634 were transported by a non-ems vehicle and so EMS went out, but they ended up going by private vehicle or police and 63,000 were treated and transported by EMS. Patrice pointed out that right now they don't have bi-directional data sharing for EMS data and there was one agency that worked to get outcome data from hospitals for quality improvements. That project went well and increasing that would be helpful. Partrice share how data sharing can help daily operations. For EMS, continuity of care from pre hospital care to emergency departments and other providers. Things like medical histories, including allergies, medications, conditions and do not resuscitate requests could be available to the EMS provider to improve care. Patrice discussed how data sharing can help community-based care which is a bigger opportunity. EMS data can help identify reoccurring issues like falls senior abuse and health needs such as management of product conditions things like diabetes that fall to that category where they may go out. EMS data can be used to identify hotspots of call locations and types for seniors to help guide community outreach. Appropriate EMS records can help identify patients that need a ride to a hospital reclining but they don't need a paramedic on board so they maybe could find a less expensive way to get there. Patrice reviewed how data sharing help emergency preparedness. Something that has been focused on is EMS data could be used to track seniors and help reunite patients with families during a disaster if there's dementia or other issues there that might be key in making sure that they find their families. Data from EMS could be valuable and evaluating the deployment of resources. A lot of this information is from the Office of the National Coordinator and is really a great resource if you're looking for more information on sharing of EMS data. There's a group in the department working on legal barriers barriers to bi-directional data sharing and there are some unique issues in sharing state data that once gotten over can be a great resource. The national system that EMS data is reported to is looking at collecting outcome data, that would be made a lot easier if we had bi-directional data sharing and hopefully that is the direction being moved into. Patrice said to contact her if anyone is interested in discussing EMS data.

Matt had a qestion, from the EMS departments perspective on the use of Telehealth in EMS, it's been a big topic both pre and during transport. There's been a lot of talk at the federal level about how do we provide tele internet connectivity to an ambulance during transport for the use of telehealth is that how much is that happening? What is the state of this?

Guy said Brianne Glenn is working in the south east corner of the state in the San Juan County area and initiative right now for telehealth for primarily for the Indian tribe down there and that's one specific grant being worked on. The biggest issue is the connectivity where we need it most is in the rural areas and the connectivity becomes problematic. There aren’t any concentrated efforts at this time but that is a vision on the roadmap.

Advanced Directives and Electronic Order for Life Sustaining Treatment : Rob Ence

Rob was excited to be a part of the conversation. The Utah Commission on Aging is a Governor's commission that has been around since about 2005. It's primary focus was initially to make sure that the state agencies were prepared with the change U demographics as the larger percentage of Utah's population moved into the older yearss. Rob said it morphed when he took it over in 2015 and changed the focus of this to less on public agency awareness and moving to putting a channel to helping the publicb be better prepared to take on the challanged and opportunities of aging. Healthcare does represent one of the greatest opportunities for us and a couple of highlights we've heard some conversation today about drug safety and utilization of drugs among older adults, but the transparency and affordability of drugs is an important issue and just overall healthcare. The fact that we spend it to three times more than other developed countries and with with less outcomes, that's data from the World Health Organization. It is staggering that 32% of Medicare dollars are spend the last two years of life.

Rob reviewed the five stages in our liefecycles and age contrubutes to those things and all the factors that take you from independent to dependency. Rob stated that according to the Surgeon General the biggest concern we have for healthcare is social isolation and shared some data that comes in part from a BYU study worse than smoking or obesity increase our healthcare costs. It's almost one out of every five individuals who is 65 Plus. The overall adverse effects in our healthcare are exacerbated by the fact that social isolation is a problem and this has become compounded again when you have situations where you already have limited sociality as in a long-term care facility. In order to protect them from each other into the current pandemic, we've had to isolate them from their whole context from family and sometimes from each other. As technology is discussed, these are all circusmtances that can have partial solutions to help alleviate. Empowerment of individuals is so important so when talking about advanced care planning, individuals can ultimately make the choice for themselves as long as they are capable. There are costs to this such as fiscal costs, human relationship costs that will impact the patients family and loved ones. When these decisions are not made, there is not clarity about what the patient wants to happen later in life. Then systems will act on us. Protocols will be followed by the healthcare industry and those are not necessarily the choices. One of the biggest challenges when working with older adults is the topic of adult literacy. You start talking about save use of pharmaceuticals. When you start talking about financial challenges that they have, you can basically substitute any of those issues shown on the chart. This includes ability to understand and navigate the challenge because they just have a limited understanding and a limited ability to comprehend that a care partner a caregiver has a challenge if they don't understand discharge papers for a patient because they want to understand but there are directions given that may not be easily understood by people and all of these things are really critical because if they're not understood well, then that leads to readmissions and other challenges in our Healthcare System. So health literacy is a really critical issue, but it also again can apply to so many other things including the safe use of technology.

The project they have been working on has been funded with the Medicare Medicaid match Grant and Dirk’s organization help support getting the funding for this. The idea is to help education individuals on how to use Pulse forms provider order of life saying treatment, but also how to have an electronic registry

in the state and that's been in play for a long time. This is moving forward with in a very positive way to get this thing all up and running by the second quarter of this coming year. During the pandemic the challenge was that pulse Agreements are medical orders and they have to be signed in person. They have to be witnessed and they there's a process they have to go through. There was a request we made for a waiver in the state of Utah so that we could bypass some of the impersonal requirements for the appropriate witnesses with appropriate verifications so that things could be done in a virtual manner. We really need the ability to to make sure that people's wishes can be documented and executed with virtual approvals, with virtual signatures, and have that be something that goes on into the future. Rob said he would like this commission to consider those things as they are having a bill drafted right now sponsored by Senator El Moto that is asking the state to adopt this policy for virtual execution of post agreements that will obviously enhance our ability on the epulse world, but just generally making sure people have their wishes acknowledged. The pandemic sort of set the need but it'll continue and is a good practice going forward and we'd love to have your input and partnership in that as well.

Rob discussed some of the barriers with technology, expanding broadband, expanding access and rural areas vulnerable populations need to have access to technology. We have got to be able to train people to use it. We need to raise the literacy of our older adults to be able to use it and to use it safely that they can have the confidence that whether they're doing telehealth, whether doing research on long-term care facilities, whether they're signing up to do a yoga class or a tenant Arts event online, all of these things are really critical.

The senior center network and area agencies on aging only serve about eight to ten percent of our older adult population and that got shut down last year and so they found a lot of individuals focusing on how do we provide services through technology and through adrc grants and a few other things they were able to get some additional technology in there. Rob was happy to have the commission organization to help build awareness and figure out how do we get this kind of access available to everybody. To enhance that programming into really tied together for the state, the commission is working with the AAA's to create Utah's Virtual Older Adult Resource Center. There is a website now as well and they'll take a one-stop right into the commission site and they will be able to connect to AAA's to programming to arts to travel to whatever as a virtual resource site specifically for Utah's and we are on the way to getting that rolled out. Rob sad he would love the grous feedback on this in the future as they try to connect all these components and make this works for our older adults in the state.

Sarah wanted to comment and asked Ron, when the bill is going to be ready, please send it to the Commission. The Commission is happy to share out our support of virtual e-pulsed as individuals. She also asked to be notifid up the virtual resource center when testing or comments are needed to get it out to the Commission.

Navina commented that it would be helpful to hear from folks what the follow up that they want tracked for the commission or actions that they want so those can be documented.

Rob stated that he will make sure to send the the bill, the majority is drafted and is in final phases. Rob also said he wanted to share an article with the group as the Commission is involved in a lot of written

communications and postings. Rob is trying to eradicate certain terms that have agist connotations and this affects healthcare and this is the way people are perceived in healthcare when certain words like elderly or even senior faces challenges. They are starting to think about ways in which we're addressing the older population in a way that is not dismissive or categorizing that'll help and just remembering to be minfdul of that. Rob will share some literature on this.

Long Term Care : Dirk Anjewierden

Dirk Anjewierden introduced himself as the Executive Director at Utah Healthcare Association. The UHA represents all of the long-term care facilities in Utah. Dirk has been in long-term care for 39 years now and is excited to have the opportunity to share some brief points about long-term care patients and the number of patients being served in long-term care has been growing significantly. There has been significant growth in the assisted living facility market. The long term care market average age population is 80+ years old. It will really take off in the number of patients being served as the baby boomers of several years ago are fitting into this group. A side note, 60% of the all patients have been into a skilled nursing facility are short-term rehab. They're post acute coming out of the hospital spend a little time in the skilled nursing facility and then get discharged to a less restrictive environment. So to that end we are becoming much more sophisticated in how we care for these patients in our efforts towards quality and that is largely accomplished through the health information technology area that the Commission deals with. Dirk said this has been viewed as so signifcantly important that an add on rate has been negotiated into the Medicaid reimbursement with the Department of Health that will pay for health information technology programs that skilled nursing facilities adopt. There is a programm in place where a facilities go out and purchase hardware or software health information technology. That is a separate at on rate to their Medicaid rate and that is done to encourage the advancement of the HIT. There is still a ways to go, communications of the hospitals is the biggest issue being worked on. UHIN and the Commission on Aging have been great partners to work with in advancing efforts.
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Sarah thanked Dirk and asked if anyone had any questions for him.

Henry said he wanted to thank all the caregivers through Covid and its challenges.

Sarah agreed and shared that Dirk's organization has stepped up massively during the covid crisis and their Partnerships are incredible. Kudos to to the Healthcare Association and all their members.

Mark had a question regarding the licensure requirements for assisted living versus long-term care. There's a moratorium, or if its still in place, a moratorium on long-term care beds. Are there any licensure restrictions on assisted living facilities?

Dirk stated that no, there are not and yes, the moratorium still in place. The difference is that skilled nursing facilities are over 80% publicly funded meaning Medicaid Medicare. The government has an interest in making sure that they operate efficiently and provide the best quality of care. Pretty much all of assisted living is private. That's private business, private enterprise in the government doesn't choose to get involved in that other than to monitor the quality of care being delivered.

Preston Marx commented that all of the presentations have just been really insightful and have a lot of intersections with each other. Preston wanted to know, on the long-term care front, they do run a long-term care facility and sustainability is really challenging from a financial standpoint so the idea or notion of interjecting Telehealth Services into that kind of a virtual long-term care facility kind of a following that at home model perhaps, what thoughts Dirk has on that.

Dirk stated that he hasn't thought much about an at-home model for long-term care. They are discharging more and more patients back to their homes after a short-term rehab. They are staying in their homes longer and have that ability to do that as far as the Telehealth side of it or the technology. There has been an increase in medical care being delivered in the skilled facilities. Since Covid has come on board, we have had to shut down to not spread disease, so actually one of maybe the benefits of that is is that we've learned how to do a better job with telehealth, getting doctors to do virtual visits and such.

Wrap Up and Next Steps:

Sarah Woolsey ran through notes that she made around potential followups for the commission. She is going to let Henry take a few minutes to wrap up Cancel RX. She is also looking at implementation and then a cost barrier that was mentioned by Preston. Sarah asked if this is something that we want to investigate and look at solutions or things the social determinants of health opportunity for the EMS partners and their data. Matt will keep an eye on opportunities for connectivity for EMS and our rural areas because that's a great opportunity with the advancing funding coming down. Our e-pulse will watch for Rob's information and for the advances in epulse to connectivity, maybe get an update of that. Once Brian feels like that project's ready to talk about again and Rob's going to send us information on improving our language around agist language and all of us could learn from him. She also mentioned the virtual older adult resource one that's ready for us to help scale that and give feedback on that.

Henry stated that he would like to see coordination with primary care physicians.

Sarah stated continue coordination with primary care physicians around everything but prescriptions.

Preston stated he was thinking one of the barriers for rural providers especially is this notion of everyone having the obligation to connect to EMS companies. For example, having that mechanism in place where UHIN could do a one-to-many type of connection would have a ton of benefit there. Follow up with that would be great.

Rand mentioned he is thinking along those lines too, of all the transitions from hospital to long-term care from specialty care in an urban setting to primary care in rural settings. It seems a lot, especially the medication issues are tied up in in those transitions and EMS as part of that as well.

Mark mentioned that a few individuals would stay on after this call to talk about topics further and anyone who wanted to discuss further was welcome to stay. He said the presentations were outstanding. Happy

with the progress the Commission is making on sharing information and ideas. Mark stated if you have any ideas about topics that should be talk about with the commission, to let him know.

Henry thanked the Commission and Sarah for the opportunity and is happy to be back and involved. He expressed his appreciation to all the presenters and is happy with the progress made.

Mark thanked everyone for presenting and coordinating. The next meeting will be March 4th and we will share what the topic of discussion will be once decided. He encouraged anyone that wanted to stay on the call and help come up with agenda topics for the remainder meetings, to stay.

Sarah wanted to mention a continued sort of attention to the health HIT plan and things they've put in there and that can attach and some great updates from today. Continuing to use that template is beneficial and we are growing within those topics that are on the HIT plan.

Meeting Adjourn.